Reset

NC01

DO NOT USE THIS SPACE

Notice of Benefit Reinstatement

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY	DATE OF DEATH (if applicable)
EMPLOYEE		
EMPLOYER		
INSURER/SELF-INSURER-TPA		
INSURER CLAIM NUMBER		

THIS IS NOTIFICATION THAT WORKERS' COMPENSATION BENEFITS HAVE BEEN REINSTATED.

Date of new payment	Amount of payment	Type of benefit	Time period covered with this payment	Compensation rate
		☐ TTD ☐ TPD ☐ PTD ☐ DEP	Date from - Date through	

Insurer: Check appropriate box and enter data information:

☐ 1. Payment resumed voluntarily. First date of new period of time lost: _____

Date of notice to employer of new period of time lost: _____

☐ 2. Payment resumed pursuant to order served and filed on _____

☐ M.S. § 176.239 decision OR ☐ Other decision (OAH, WCCA, or Supreme Court)

☐ 3. TPD changed to TTD effective _____

☐ 4. Full wage continuation changed to TTD effective _____

Please provide the following pre-injury wage information <u>ONLY</u> if it differs from prior submissions:

Average Weekly Wage	Weekly value of:	Meals	Lodging	2nd income

Straight time:

Rate per hour	Hours per day	Days per week	26 week earnings	Total days worked in last 26 weeks	Total weeks worked in last 26 weeks

IF OVERTIME IS PAID OR IF EMPLOYEE IS IRREGULARLY SCHEDULED, ATTACH A 26 WEEK WAGE STATEMENT.

CLAIM REPRESENTATIVE NAME	PHONE # (include area code)	DATE

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.